



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
P.O. Box 11729  
Albany, NY 12211

## **NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL**

Notice Date: October 3, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000008417

[REDACTED]

Dear [REDACTED]

On March 23, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination, stating that you, your spouse, and your two children were eligible for the Essential Plan, and your youngest child was eligible for Child Health Plus effective May 1, 2016. You appealed that determination.

On September 29, 2016, a Hearing Officer from the Appeals Unit of NY State of Health called you and placed you under oath.

While under oath, you identified yourself and stated that you were no longer interested in pursuing your appeal because you did not have any outstanding bills during the month your household was without coverage, and did not see a reason to go forward with an appeal hearing at this time.

You therefore withdrew your appeal on the record. Accordingly, we are dismissing your appeal, pursuant to 45 Code of Federal Regulations (CFR) § 155.530(a)(1).

### **How does this Dismissal Affect Your Eligibility?**

The Appeals Unit of NY State of Health will not be reviewing this matter at this time.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY – English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

## **If You Think Your Appeal Should Not Be Dismissed**

If you think your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice.

NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing.

If you do not respond to this notice within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

## **Appeal Identification Number**

When communicating with NYSOH about this appeal, please reference Appeal Identification Number at the top of this notice.

## **How to Contact NYSOH**

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:  
NY State of Health Appeals  
P.O. Box 11729  
Albany, NY 12211
- By fax: 1-855-900-5557

## **Legal Authority**

We are sending you this notice in accordance with 45 CFR § 155.530.

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**A Copy of this Notice of Dismissal Has Been Provided To**



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